MAXIMUS Federal Services

Case Number:	CM15-0073118		
Date Assigned:	05/11/2015	Date of Injury:	05/09/2008
Decision Date:	07/07/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/16/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Utah, Arkansas
Certification(s)/Specialty: Family Practice, Sports Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 43-year-old female, who sustained an industrial injury on 5/9/08. She reported neck and left shoulder injury. The injured worker was diagnosed as having myofascial pain syndrome, cervical spine strain and left shoulder rotator cuff syndrome. Treatment to date has included oral medications including opioids, home exercise program, trigger point injections, physical therapy and epidural steroidal injections. Currently, the injured worker complains of increased pain in left trapezius and paracervical with numbness. Physical exam noted left shoulder positive impingement, decreased sensation of left shoulder and decreased range of motion of left shoulder and neck. The treatment plan included request for authorization for Voltaren, trigger pint injections, LidoPro and Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

1 prescription of Neurontin 600mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page(s) 16, 49.

Decision rationale: MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the above cited guidelines, "Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy." To determine a good outcome, "A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction." "It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the 'trigger' for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use." According to the clinical documents, the guidelines for use of Neurontin have not been met. According to the clinical documentation provided and current MTUS guidelines, Neurontin is not medically necessary to the patient at this time.

1 prescription of Voltaren XR 100mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel, page 112. Diclofenac.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Voltaren Gel. MTUS guidelines state the following: Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. There is lack of documented relief with previous Voltaren gel usage. According to the clinical documentation provided and current MTUS guidelines, Voltaren Gel is not medically necessary to the patient at this time.

1 prescription of LidoPro #2: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): . 111-112..

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Lidopro. MTUS guidelines state that Lidocaine may be used for peripheral pain, after there has been a trial of first-line therapy (such as tri-cyclic or SNRI antidepressants or AED such as gabapentin or Lyrica) Topical lidocaine in the form of a patch has been designated for orphan status by the FDA for neuropathic pain. According to the clinical documentation provided and current MTUS guidelines, First line medications were used previously to the Lidoderm patches. The patient is currently on Neurontin. Therefore, Lidoderm Patch is medically necessary to the patient at this time.

8 chiropractic manipulation sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, page(s) 58-60.

Decision rationale: MTUS guidelines state the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. According to the request it is unclear what the goals of manual medicine are, and what body parts would be involved in the treatment. The patient has a diagnosis of neck and upper extremity pain; these areas are not recommended as an option. According to the clinical documentation provided and current MTUS guidelines, Chiropractic manipulative treatment is not medically necessary to the patient at this time.

4 trigger point injections: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections 122-123.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Trigger point injections. MTUS guidelines state the following: Trigger point injections. Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane,2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections

with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The patient has not met these above criteria for an injection. According to the clinical documentation provided and current MTUS guidelines, Trigger point injections are not medically necessary to the patient at this time.